Department of Employee Trust Funds
Group Health Insurance
P.O. Box 7931
Madison, WI 53707-7931

HEALTH INSURANCE INFORMATION CHANGE

This form is to be completed by a subscriber who is only revising relevant information. Transactions such as changing HMOs or changing from single to family coverage require a new health application (ET-2301) and should not be submitted on this form.

SUBSCRIBER:
Complete Sections 1-4

Return to employer *(if active employee)* or the Department of Employee Trust Funds *(if retiree or continuant)*

Employer Name: _____

1. Name _____ Birthdate _____ SS # _____
   Health Insurance Plan _____ Present Coverage: ☐ Single ☐ Family
   Subscriber # _____ Group # _____
   (If retiree or continuant) I was a dependent or spouse of _____ _____
   (Name) *(Social Security Number)*

2. Check the box(es) indicating the type(s) of change(s): Event Date _____
   ☐ Name change (list former name) _____
   ☐ Address change to: Street: _____
   County _____ City: _____ State: _____ Postal Code: _____
   ☐ Home Phone # _____ ☐ Daytime Telephone # _____
   ☐ Social Security # _____ for _____
   ☐ Update other insurance coverage for: _____
   Through State of WI, including University of WI? ☐ No ☐ Yes
   Insurance Company _____
   Group # _____ Subscriber/Policy # _____
   Name of Employer _____ Medicare? ☐ No ☐ Yes
   Name of Insured _____ Effective Date _____

3. Complete the following for additions, deletions or when selecting a different primary care physician.
   Event Date _____
   ☐ Adding a dependent ☐ Deleting a dependent *[Do not use this form to remove last dependent. Please complete new health application (ET-2301) to change to single coverage.]*
   Reason: ☐ Marriage ☐ Divorce ☐ Age ☐ Student Status ☐ Birth ☐ Legal Ward
   ☐ Adoption ☐ Disabled Is spouse State of WI employee, including University of WI ☐ Yes ☐ No
   ☐ Primary Care Physician Change: Change in subscriber's physician county ☐ No ☐ Yes
   Effective Date Authorized by Plan _____ Reason for Change _____
   Some plans allow changes at anytime; others do not. Check with your plan, then file this form. The effective date of the physician change is determined by the plan. Any change in your share of premium is effective on the first of the month following receipt of the form by your employer.

Last Name	First	Middle	Birthdate Mo	Da	Yr	Sex	SS#	Rel. To Subscriber	Selected Physician	County	Provider No.

* Dependents include spouse and children. Children include those who are dependent upon you and/or the other parent for at least 50% of their support, meet the support tests as a dependent for federal income tax purposes and are your natural children, legal wards who become your permanent ward prior to age 19, adopted children, stepchildren, or children of your dependent child until your child reaches age 18.

4. To the best of my knowledge, all statements and answers in this application are complete and true. All information is furnished under penalty of Wis. Stat. § 943.395.
   Subscriber Signature _____ Date _____

EMPLOYER COMPLETES AREA BELOW Coding instructions are in the Employer Manual

Enrollment Type	Employee Type	Coverage Code	Carrier Suffix	Standard Plan Waiting Period	Participant County	Physician County	Payroll Representative Signature	Telephone
65								

Name of Employer	Employer Number	Group Number	Date Received by Employer
	69-036-		

Monthly Employee Share	Monthly Employer Share	Date Employment Began *(MM/DD/CCYY)*	Event Date	Prospective Date of Coverage *(MM/DD/CCYY)*
$	$			

ET-2329 (REV 09/2003)